United States Court of Appeals

for the Second Circuit

AMICUS BRIEF

74-1874

IN THE

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

B

P/S

No. 74 - 1874

SUSAN ROE, et al.

Plaintiffs, Appellees

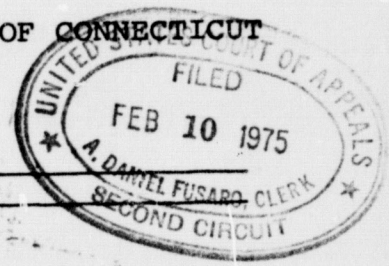
v.

NICHOLAS NORTON, et al.

Defendants, Appellants

ON APPEAL FROM A DECISION OF THE

UNITED STATES DISTRICT COURT, DISTRICT OF CONNECTICUT



MEMORANDUM FOR THE UNITED STATES AS AMICUS CURIAE

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MEMORANDUM FOR THE UNITED STATES AS AMICUS CURIAE

This memorandum is submitted in response to the Court's invitation to the General Counsel of the U. S. Department of Health, Education, and Welfare to file a memorandum expressing the views of the United States on the issues raised on appeal by the parties in this case.

ISSUES

The United States will discuss two statutory questions which involve matters which fall within the province of the Secretary of Health, Education, and Welfare:

1. Whether title XIX of the Social Security Act precludes a federally funded state Medicaid program from paying for abortions which are not "medically necessary";

2. Whether title XIX requires a state to make Medicaid payments for such abortions.

STATEMENT

For the reasons discussed below, it is the position of the Secretary of Health, Education, and Welfare that title XIX of the Social Security Act neither compels nor precludes payment for abortions which are not "medically necessary."

Pursuant to title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., the Federal Government provides funds for state programs of medical assistance to certain families with dependent children and to aged, blind, and disabled individuals. In order to qualify for federal funding, states electing to establish such programs, commonly called "Medicaid" programs, must satisfy the requirements of 42 U.S.C. 1396a. Among those conditions is the requirement that "medical assistance [be provided]... with reasonable promptness to all eligible individuals." 42 U.S.C. 1396a(a)(8).

"Medical assistance" is defined in 42 U.S.C. 1396d(a) as payment for all or part of a broad range of types of medical care and services. A state need not include in its Medicaid program all the categories of assistance described in that provision, however; in order to qualify for federal funding it is required to cover only those items enumerated in subsections (1) through (5): inpatient and outpatient hospital services, other laboratory and X-ray services, skilled nursing facility services, early and periodic screening, diagnosis and treatment of children, family planning services and supplies, and physicians' services.

42 U.S.C. 1396a(a)(13)(B), 1396d(a)(1)-(5). 1/ Nor must the state include every kind of medical treatment encompassed within these five provisions. The operative state plan requirement with respect to the adequacy of the amount, duration and scope of the states' program coverage is whether the state has "reasonable standards...for determining...the extent of medical assistance under the plan which...are consistent with the objectives of [title XIX]..." 42 U.S.C. 1396a(a)(17).

1/ The other types of care and services authorized in section 1396d are set out in subsections (6)-(17): (6) medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law; (7) home health care services; (8) private duty nursing services; (9) clinic services; (10) dental services; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select; (13) other diagnostic, screening, preventive, and rehabilitative services; (14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases; (15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1396a(a)(31)(A), to be in need of such care; (16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under 21, as defined in subsection (h); (17) any other medical care, and any other type of remedial care recognized under state law, specified by the Secretary.

Within the bounds of the statutory criterion of "reasonableness", the states have considerable discretion in forming the content of their Medicaid programs. And, indeed, the programs are characterized by a high degree of diversity from state to state, reflecting each state's own determination of its medical and social priorities. States may, if they choose, offer only the items of medical assistance mandated in 42 U.S.C. 1396d(a)(1)-(5); but at its outer limits the Act allows the states the scope to institute comprehensive and wide-ranging medical programs. 2/ States can, for example, either include or exclude clinic services, prescribed drugs, dentures, physical therapy, inpatient psychiatric care for children, rehabilitative services, and certain non-mandatory preventive services.

2/ While the scope of title XIX coverage is broad, it is more limited than it may perhaps appear. 42 U.S.C. 1396d(a)(6) permits the inclusion of "medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law." The purpose of this provision is to permit the states, if they so choose, to pay the costs of medical services performed by certain licensed practitioners, such as chiropractors, who are not physicians. Thus that provision may not be read as requiring the states to pay for all medical services, whether or not necessary.

DISCUSSION

Title XIX Does Not Preclude Coverage of Abortions Which Are Not Medically Necessary.

The objectives of the Medicaid program include the furnishing of "medical assistance on behalf of [eligible individuals] whose income or resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. 1396. 3/ Appellants view that provision as effectively requiring a finding that a medical service is "necessary" (or, in their terms, "medically necessary") if the service is to be federally reimbursed with Medicaid funds. They contend that this means that an abortion that is not certified as "medically necessary" -- that is, required for the physical or psychological health of the mother -- by the patient's attending physician may not be paid for under title XIX (Brief of Appellant, pp. 3-4). We disagree with that view of the Act.

3/ The purposes of title XIX are more fully stated as follows:

> "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title." 42 U.S.C. 1396.

While 42 U.S.C. 1396 and 1396a(a)(10)(C)(i) employ the term "necessary medical services", the phrase has never been construed as a limitation upon the types of medical care and services which can be offered under the Act to those services essential to life or health. The term does not appear in the statutory provision defining "medical assistance," section 1396d(a). Moreover, the Act, by its very terms, is broad enough to permit services, such as annual physical checkups and other preventive care, which would not ordinarily be considered "medically necessary" in the sense that they were essential to preserve physical or mental health. Further, the purposes of the Act -- to provide medical assistance to certain indigent persons -- are not frustrated by virtue of the fact that one state pays for services which another state does not deem "necessary."

Thus, it is the Secretary's position that abortions which are not "medically necessary" may be reimbursed under title XIX if the state chooses to cover them in its program. 4/ Coverage of such abortions is not inconsistent

4/ Federal Medicaid reimbursement for abortions is available pursuant to a number of provisions of section 1396d(a), such as hospital or physicians' services or, if the state elects to include them in its program, clinic services. A federal rule has been proposed, however, to preclude such reimbursement for abortions as "family planning services and supplies" pursuant to section 1396d(a)(4)(C), which services and supplies are matched at a higher federal rate than are other services and supplies. 42 U.S.C. 1396b(a)(5).

with the Act, and would be consistent with, rather than violative of, the 42 U.S.C. 1396a(a)(17) state plan criterion of "reasonableness."

Title XIX Does Not Require Payment for Abortions Which Are Not Medically Necessary.

On the other hand, the federal statute in our view does not require the states to provide Medicaid coverage for abortions which they do not find "medically necessary", and a state may decline to pay for such services. 5/

We consider it "reasonable" for a state to refuse to extend Medicaid coverage to unnecessary medical services, such as cosmetic surgery, which even many non-needy persons cannot afford or may be unwilling to pay for. In our view, such restricted coverage would be consistent with the objectives of title XIX. 6/ Similarly, we consider

5/ Although there have been several constitutionally-based federal court decisions holding that states may not decline to provide for abortions under their Medicaid programs, the only other court decision of which we are aware on the question whether title XIX requires the states to furnish abortions held that it does not. Doe v. Wohlgemuth, 376 F. Supp. 173 (W.D. Pa. 1974).

6/ 42 U.S.C. 1396a(a)(30) speaks in terms of the "unnecessary utilization" of services; that provision and implementing regulations at 45 C.F.R. 250.18-20, governing utilization control of care and services, 39 F.R. 41610 (November 29, 1974), are directed not toward restricting the provision of medical care under Medicaid to only the most vital life and health-saving measures but, rather, must be read in the context of the purposes of the utilization review provisions of the Act, which are designed to assure that the medical care and service provided under the programs are appropriate, reasonably priced, and effective.

it reasonable for a state to refuse to pay for the cost of medical services that exceed appropriate limitations established in the interests of fiscal control, such as limitations on the number of days of inpatient hospitalization or on the number and kinds of prescription drugs that will be compensable under Medicaid. Indeed, the Department's regulations provide that appropriate limits placed on medical services based on medical necessity, utilization controls, or medical review procedures do not render the medical services insufficient in amount, duration, and scope to reasonably achieve their purpose, and (with respect to required services) do not constitute an arbitrary denial or reduction in the amount, duration, or scope of such services. 45 C.F.R. 249.10(a)(5)(i).

The Social Security Act does not require reimbursement of the costs of all medically feasible abortions performed merely upon the demand of pregnant women. An abortion is a serious medical matter which requires the exercise of medical judgment and a state requirement that the procedure be determined "medically necessary" would not be inconsistent with the Act. A state need not provide financial assistance with respect to all other medical services --

such as, for example, a tonsillectomy -- merely upon the patient's own request, and there is no apparent reason why abortions should be treated differently. While the practical and emotional consequences of a failure to perform an abortion may be profound, the same may be said of the failure to perform a medically feasible transsexual operation; yet a state presumably could reasonably determine not to provide such operations when they are not medically necessary. Furthermore, the experience of an abortion could have far-reaching and unforeseen consequences for the pregnant woman's psychological health, and there would thus appear to be special reasons for requiring the medical judgment before the state undertakes to provide the woman with a requested abortion. A state's requirement of such an exercise of medical judgment is not so lacking in rationality as to be "unreasonable" for purposes of 42 U.S.C. 1396a(a)(17).

Similarly, we believe that title XIX of the Social Security Act does not preclude a requirement in a state's Medicaid program of prior approval by the state. Indeed, where a state wishes to ensure that limited resources will be used only for medically necessary procedures, a requirement of prior approval for Medicaid payments may

be the most efficient way of administering the program in the best interests of the recipient. See 42 U.S.C. 1396a (a)(19). A reasonable prior authorization expeditiously handled would not be inconsistent with title XIX.

CONCLUSION

For the foregoing reasons, the Department believes that a state requirement that an abortion be certified as medically necessary is neither required by title XIX of the Social Security Act, nor precluded by that statute. Under title XIX states have great flexibility, within the bounds of reasonableness, in defining the amount, duration, and scope of medical care and services; and imposition of a requirement that the service be medically necessary in the provision of some or all of those services, so long as such requirement is reasonably applied, is consistent with the statute.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

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